Supreme Court, U.S.
FILED
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No.

IN THE

Supreme Court of the United States

JAMES G. FRANKE, AND ALL OTHERS SIMILARLY SITUATED, PETITIONER

v.

POLY-AMERICA MEDICAL AND DENTAL BENEFITS PLAN

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

A. Whether The Decision of the Eighth Circuit Promotes the Supremacy of Arbitration Clauses to the Level Where They Are Enforced Despite Being Illegal and Unduly Inhibiting the Ability of Claimants to Exercise Their Rights under ERISA.

B. Whether A Decision by this Court Would Clarify the Tension Between Circuits Regarding the Enforceability of Illegal Arbitration Provisions.

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JURISDICTION

The decision of the United States Court of Appeals for the 8th Circuit, reversing the decision of the District Court's Order was handed down on March 6, 2009. A timely Petition for Rehearing and Rehearing En Banc was denied on March 12, 2009. This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

RELEVANT PROVISIONS INVOLVED

(see appendix)

STATEMENT

This case has broad implications because the decision of the 8th Circuit limits and inhibits the rights of all persons seeking benefits governed by ERISA. The 8th Circuit decision presents an important issue regarding whether the Federal Arbitration Act (FAA) nullifies Labor Department regulations intended to provide safeguards for ERISA governed employees, who typically are significantly less informed and

sophisticated than their employer on these matters, in the appeals processing of claims. Moreover, the decision promotes the development of illegal or unfair appeals processes in ERISA appeals by concluding that a severability clause (even one which limits the arbitrator from ordering changes to the Employee Benefit Plan) solves any overreaching. Finally, the case presents an opportunity to resolve differences among the circuits which have reviewed similar issues involving overreaching arbitration provisions dealing with statutory rights.

A. Factual Background

James G. Franke is a Poly-America service parts employee who is covered under its ERISA governed medical and dental benefit plan (The "Plan"). After a myocardial infarction, he incurred substantial hospitalization bills which were denied by the Plan based upon a smoking exclusion. Franke then brought this action alleging that the exclusionary provision of the plan upon which the denial was based was so broad as to be unenforceable, and the appeal process of the Plan was illegal. Because these issues affected all participants in the Plan the matter was brought as a class action. Suit was filed without Franke's participating in the Plan's mandatory arbitration provisions contained in the Plan's appeals process because he believed said provisions were illegal and unenforceable. Prior to class certification the Plan brought a Motion to Compel Arbitration and Stay the District Court Proceedings. The District Court denied the defendant's motion declaring the arbitration agreement to be illegal and unenforceable. On appeal

the 8th Circuit reversed the trial court and ordered the employee to arbitration, notwithstanding the illegal provisions of the agreement.

B. The Illegal Provisions of Poly America's Appeals Process.

The subject matter appeals process is contained at App. p. 13-14a. It violates ERISA legislation and case law in the following ways:

1. The Plan calls for mandatory *mediation*, with the employee paying half the costs (App. p. 17a¶6.).

2. The Plan calls for mandatory *arbitration* with the employee paying half the costs. (App p. 15a¶1, 19a¶8). Both the arbitration and mediation provisions calling for the employee to pay half the costs are in violation of §29 CFR 2560.503-1(b)(3) which specifically provides that appeals processes which require employees to pay fees or costs as a condition to making a claim or appealing an adverse benefit determination unduly inhibits the initiation and processing of claims for benefits.[1]

3. The Plan calls for three or four appeals while regulation §29 CFR 2560.503-1(c)(2) calls for only two appeals. The Poly America appeals process calls for an initial appeal, a grievance appeal, a mandatory

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[1]Defendant claimed it was willing to waive the cost sharing in Franke's particular claim, but made no offer to rewrite the appeals process of the Plan, and offered no cogent argument as to why the illegal arbitration provisions were placed in the appeals process in the first place, demonstrating this was an attempt to overreach at conception.

mediation, and a binding arbitration (App. p.14-16a).

4. The plan misleads and creates an ambiguity with regard to an employee's right to proceed to Federal Court. The right to appeal to Federal Court is found in small print (App. p.24a¶17). However, immediately preceding the section on arbitration in lettering two to three times as large and in bold print and underlined, there is a directive stating that final and binding arbitration is the sole remedy. (App. p.14a)

5. While the Plan allows for severability and modification by the arbitrator in an employee's individual case, it specifically forbids the arbitrator to mandate that Poly America actually change the plan to revise the illegal provisions, stating, "The arbitrator shall not have the authority to require the company to alter or otherwise amend the terms of the plan." (App. p 19a¶9)[2]

REASONS FOR GRANTING THE PETITION

A. The Decision of the Eighth Circuit Promotes the Supremacy of Arbitration Clauses to the Level Where They Are Enforced Despite Being Illegal and Unduly Inhibiting the Ability of Claimants to Exercise Their Rights under ERISA.

There is no dispute that Mr. Franke agreed to the subject matter arbitration agreement in writing. There is also no dispute that statutory rights can be

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[2]This clause, distinguishes Franke's situation from any case cited in support of the 8th Circuit opinion, but is not discussed by the Court.

adjudicated by means of arbitration. Green Tree Financial Corp. v. Randolph, 531 U.S. 79, 121 S.Ct. 513 (2000) However, statutory rights can be adjudicated by means of arbitration only "so long as the prospective litigant effectively may vindicate (his or her) statutory cause of action in the arbitral forum," Id. p. 648. Quoting Mitsubishi Motors Corp. v. Soler Chrysler/Plymouth Inc., 473 U.S. 614, 637, 105 S.Ct. 3346 (1985) The Poly America Plan does not meet this test in the context of ERISA, a statutory scheme intended to protect unsophisticated employees from unfair loss of employee benefits.

To safeguard the effectiveness of the appeals process in an ERISA setting §29 CFR 2560.503-1(b)(3) provides that to be in conformity with ERISA,

> "The claims procedures do not contain any provision, and are not administered in a way that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits."

In the Poly-America appeals process, the employee is required to proceed to a mediation in which he or she shares costs, and to an arbitration in which he or she shares costs. (App. p.17a¶6, 15a¶1, 19a¶8)

Another regulation §29 CFR 2560.503-1, calls for only two appeals in an ERISA appeal process.

Whether the Poly-America appeals process of an initial appeal, a grievance appeal, a required mediation, and then an arbitration, is a violation of the two appeals rule, or whether such a multiple step process "unduly inhibits the initiation or processing of claims for benefits," the result is the same for the employee-his or her appeal of claims is complicated, diminished and/or threatened by the process.

The Plan also misleads regarding the employee's rights to bring an action in Federal Court. The Plan's bold directive stating, **"FINAL AND BINDING ARBITRATION IS YOUR SOLE REMEDY IF YOU ARE DISSATISFIED WITH YOUR TREATMENT UNDER THE PLAN"** (App. p. 14a)[3] misleads employees as to their right to a federal court remedy, in violation of 29 CFR §2520.102-3(t)(1).

The severability and modification clause in the arbitration portion of the appeals process does not remedy the illegality of the Plan, because the arbitrator has no authority to require the company to change the Plan. Specifically the Plan indicates: "The arbitrator shall not have the authority to require the company to alter or otherwise amend the terms of the Plan or require any action by the company or the Plan Administrator that is contrary to the terms of the Plan." (App. p. 19a¶9)

Equally importantly, the employees are not lawyers and do not know that many of the Plan's

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[3]This specific language had already been declared a violation of ERISA in Christianson v. Poly America, 2002 WL 31421684 (D. Minn.) but never changed by Poly America.

provisions are illegal. Moreover, the test of whether the appeals process inhibits the rights of the employees is the effect of the Plan as being read by the employee, not the severed and modified and legalized Plan that some enlightened arbitrator may make on behalf of the employee. 29 CFR §1022(a) indicates that summary plan descriptions must be written in a manner to be understood by "the average Plan participant", and must comply with requirement that an "employee should not be required to adopt the skills of a lawyer" in order to comprehend the language in his or her own ERISA plan. Barker v. Ceridian Corp., 122 F.3d 628, 634 (8th Cir. 1997).

By ignoring these shortcomings in the Poly America Plan, the 8th Circuit's decision favors the Federal Arbitration Act to the point where another congressional act, namely ERISA, which was intended to protect and ensure employee rights, is weakened and its regulations nullified.

B. A Decision by this Court Would Clarify the Tension Between Circuits Regarding the Enforceability of Illegal Arbitration Provisions.

The 4th Circuit in Hooters of America, Inc. v. Phillips, 173 F.3d 933 (4th Cir. 1999) held that when an arbitration provisions contains several illegalities the proper remedy is to declare the entire arbitration process invalid and unenforceable. Id. at 940.

The 9th Circuit reached a similar conclusion in Ingle v. Circuit City Stores, Inc. 328 F.3d 1165, 1180 (9th

Cir. 2003) where the Court found an employment arbitration agreement to be illegal and unenforceable and pointed out that attempting to ameliorate the illegal aspects of an arbitration agreement requires the court to be a contract author rather than an interpreter. The 9th Circuit in Graham Oil Co. v. ARCO Products Co., 43 F.3d 1244, 1248-49 (9th Cir. 1995) held that in an arbitration clause that purported to waive statutory rights was invalid and the inseverability clause could not save it, pointing out the arbitration clause itself was part of a larger process containing three difference illegal provisions (there are probably at least four in the instant case) the severability clause could not save the agreement.[3]

CONCLUSION

As the length of the 8th Circuit opinion and this Petition demonstrates, this is not a complicated case. However, it is an important case as many thousands if not millions, of employees have ERISA governed plans which they rely on as an ultimate safety net.

While there is good reason to embrace

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[3]The instant case is probably a stronger case for declaring the arbitration agreement and appeals process of Poly-America unenforceable because none of the clauses in the above cases contained the specific admonition that the arbitrator could not direct the Company to make changes to its Plan regarding the illegalities, nor did they deal with violation of specific ERISA regulations. Moreover, the 8th Circuit in Bond v. Twin City Carpenters Pension Fund, 307 F.3d 704 (8th Cir. 2002) held that an ERISA mandatory binding agreement clause cannot contain cost splitting provisions as that would unduly inhibit and hinder the claims process.

arbitration in many situations, in this particular instance the 8th Circuit's decision creates an unfortunate precedent for all ERISA employees whereby an employer may create a daunting, burdensome, costly, and inhibiting claims process in direct violation of Labor Department regulations and case law, and the court will still enforce it. The Appeals Court decision orders no sanction for developing an illegal claims process, so Employers such as Poly America can be caught with its hand in the cookie jar and not even be ordered to put the cookie back.

The danger in the argument that a severability clause cures the problem is that an employee faced with this daunting appeals process, and who will not have the legal background to know it is illegal, does not even know to ask an arbitrator to legalize it. In many instances, unless the arbitrator is an ERISA expert, even he/she would not be aware of all of the illegalities. The court need only look at the offending document (App p 12a-25a) to know that an employee confronted with it would probably just give up on any appeal.

This case presents a clear-cut and important opportunity for the Court to balance the utility of arbitration with the need for the availability of an uninhibited, full, and fair review for ERISA employees asserting their rights. A bright line rule striking down the provisions before this Court would likely also reduce future litigation regarding this important issue.

Respectfully submitted,
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No. 08-1637

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

James G. Franke, and all others similarly situated,
Appellee,
v.
Poly-America Medical and Dental Benefits Plan,
Appellant.

November 14, 2008, Submitted
February 5, 2009, Filed

Appeal from the United States District Court for the District of Minnesota.

COUNSEL: For James G. Franke, and all others similarly situated, Plaintiff - Appellee: Jodell Marie Galman, Mark Murray Nolan, NOLAN & MACGREGOR, St. Paul, MN.

For Poly-America Medical and Dental Benefits Plan, Defendant - Appellant: Stephen P. Lucke, Glenn M. Salvo, DORSEY & WHITNEY, Minneapolis, MN.

JUDGES: Before WOLLMAN, BEAM, and BENTON, Circuit Judges.

OPINION

WOLLMAN, Circuit Judge.

Poly-America Medical and Dental Benefits Plan (the Plan) appeals from the district court's denial of its

motion to compel arbitration. We reverse and remand for entry of an order compelling arbitration.

I.

James G. Franke has been employed by Up-North Plastics Inc., an affiliate of Poly-America, L.P., since 2001. Through this employment, Franke enrolled in the Plan, which is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq. During each year of his employment, Franke acknowledged in writing his agreement to arbitrate any claims associated with his enrollment in the Plan.

After suffering a myocardial infarction in November 2006, Franke submitted his medical bills to the Plan for payment. Following the denial of his request for payment, Franke appealed to the Plan Administrator, Chuck Kramer, who upheld the original decision. Kramer informed Franke that he could "file a written request with the Plan Administrator for final and binding arbitration."

Franke chose instead to file suit in federal district court. The Plan moved to compel arbitration. In its submissions to the court, the Plan recognized that certain provisions in the arbitration agreement were unlawful under ERISA, but argued that those provisions should be corrected pursuant to the severability clause in the contract and that the arbitration agreement should be enforced. The district court disagreed, however, and concluded that "the mere existence of the illegal provision, in this instance, unduly inhibits or hampers the processing of appeals

and therefore renders the arbitration requirement in the Plan unenforceable."

II.

We review *de novo* the district court's denial of the Plan's motion to compel. *EEOC v. Woodmen of the World Life Ins. Society*, 479 F.3d 561, 565 (8th Cir. 2007). The Federal Arbitration Act (FAA) requires that "[a] written provision in any . . . contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2. The FAA intended "to reverse the longstanding judicial hostility to arbitration agreements . . . and to place arbitration agreements upon the same footing as other contracts." *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 24, 111 S. Ct. 1647, 114 L. Ed. 2d 26 (1991). "In light of this federal policy, arbitration agreements are to be enforced unless a party can show that it will not be able to vindicate its rights in the arbitral forum." *Faber v. Menard, Inc.*, 367 F.3d 1048, 1052 (8th Cir. 2004). This strong federal policy applies equally to claims grounded in statutory rights, and we have found no "compelling basis to treat agreements to arbitrate ERISA claims differently." *Arnulfo P. Sulit, Inc. v. Dean Witter Reynolds, Inc.*, 847 F.2d 475, 479 (8th Cir. 1988). When reviewing the enforcement of an arbitration agreement, we determine only whether there is a valid arbitration agreement and whether the dispute at issue falls within the terms of that agreement. *Faber*, 367 F.3d at 1052. If there is a valid agreement and the dispute is properly

within the terms of the agreement, the agreement must be enforced.

Franke concedes that the dispute falls within the agreement. He argues, however, that certain provisions contained in the agreement are in violation of ERISA and thus undermine the agreement to arbitrate. As noted by the district court, the two provisions that appear to be unlawful are the agreement's assertion that arbitration is binding and the requirement that arbitration costs be shared. Despite the presence of these two provisions, the agreement before us is distinguishable from the cases on which Franke relies. For example, it does not approach the "sham system unworthy even of the name arbitration" at issue in *Hooters of America, Inc. v. Phillips*, 173 F.3d 933, 940 (4th Cir. 1999). In that case, the agreement was riddled with biased provisions that allowed Hooters, among other things, to choose the arbitrators and unilaterally modify the arbitral rules without notice, presumably even during arbitration. *Id.* at 938-39. A member of the American Arbitration Association's board of directors testified that the agreement was "without a doubt the most unfair arbitration program I have ever encountered." *Id.* at 939. Equally misplaced is Franke's reliance on *Graham Oil Co. v. Arco Products Co.*, 43 F.3d 1244 (9th Cir. 1994), for the proposition that the mere presence of unlawful provisions can invalidate an arbitration agreement, given that we have refused to follow its holding. *See Larry's United Super, Inc. v. Werries*, 253 F.3d 1083, 1086 (8th Cir. 2001).

Rather, the case before us is more akin to the facts in *Woodmen*, *Faber*, and *Gannon v. Circuit City Stores, Inc.*, 262 F.3d 677 (8th Cir. 2001). In each of those cases

the severability clause found in the arbitration agreements "specifically state[d] the intent of the parties in the event a provision within the agreement is found invalid," i.e., that arbitration proceed once any invalid terms have been severed. *Gannon*, 262 F.3d at 680. The same is true here. Although Franke and the district court voice the concern that Plan participants "cannot be expected to know" that the provisions at issue are unlawful, that is not a sufficient basis upon which to deny the motion to compel. "We will not extend [our limited] review to the consideration of public policy advantages or disadvantages resulting from the enforcement of the agreement." *Faber*, 367 F.3d at 1052 (citing *Gannon*, 262 F.3d at 682) (internal quotations omitted).

The judgment is reversed, and the case is remanded to the district court for entry of an order compelling arbitration under the Plan as modified pursuant to the stipulated-to amendment.

Civil No. 07-3990 (PAM/JSM)
UNITED STATES DISTRICT COURT DISTRICT OF MINNESOTA
James G. Franke and all others similarly situated,
Plaintiffs,
v.
Poly-America Medical and Dental Benefits Plan,
Defendant.

MEMORANDUM AND ORDER

This matter is before the Court on Defendant's Motion to Compel Arbitration and to Stay. For the reasons that follow, the Court grants the Motion.

BACKGROUND

Plaintiff James Franke is employed at Up-North Plastics, Inc. As a benefit of his employment, he is covered by an employee health plan, Defendant Poly-America Medical and Dental Benefits Plan (the "Plan"). In November 2006, Franke had quadruple-bypass surgery. The Plan refused to pay for the surgery because the terms of the Plan exclude "[c]harges associated in any way, shape, manner or form with the Participant's smoking or with the Participant's use of tobacco products, including complications associated in any way, shape, manner or form with the Participant's use of tobacco." (Berman Aff. Ex. B at 20 (italics in original).) At least for the purposes of this Motion, Franke does not dispute that he is a life-long heavy cigarette smoker.

Franke's claim for benefits was denied on reconsideration. Franke then filed this lawsuit. The

Plan contends that its mandatory arbitration provision requires the Court to stay this matter and refer it to an arbitrator. Franke asserts that the Plan's arbitration clause is invalid. He purports to represent a class of individuals covered by the Plan challenging the Plan's smoking exclusion.

DISCUSSION

The Plan contends that Franke must first submit his claim to arbitration before bringing a lawsuit. Franke maintains that the arbitration provisions in the Plan violate the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq., and therefore that the Court should not require him to arbitrate. As an initial matter, the Court notes the strong federal policy in favor of arbitration. Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24 (1983) (noting the "liberal federal policy favoring arbitration agreements"). The essence of the Plan's argument in this Motion is that by not submitting his claims to arbitration, Franke has failed to exhaust his administrative remedies. See Wert v. Liberty Life Assurance Co. of Boston, 447 F.3d 1060, 1063 (8th Cir. 2003).

The Plan contains extensive and detailed arbitration provisions. Those provisions state that "FINAL AND BINDING ARBITRATION IS YOUR SOLE REMEDY IF YOU ARE DISSATISFIED WITH YOUR TREATMENT UNDER THE PLAN." (Berman Aff. Ex. B. at 45.) Franke repeatedly acknowledged his obligation to arbitrate. (Berman Aff. Ex. C at 2-5.)

The regulations governing ERISA plans mandate that "every employee benefit plan shall establish and maintain reasonable procedures governing ... appeal of adverse benefit determinations." 29 C.F.R. § 2560.503-1(b). That subsection further provides that "claims procedures for a plan will be deemed reasonable only if" those procedures comply with the ERISA regulations and if the procedures "do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits." Id. § 2560.503-1(b)(3). Franke argues that several portions of the arbitration provisions in the Plan "unduly inhibit[ed] or hamper[ed]" the processing of his claim, and therefore that the Plan's arbitration provisions are unenforceable.

First, Franke argues that the Plan provides for three levels of review, which is contrary to ERISA. However, the Plan provides for only one level of administrative review after the initial claim denial. Thus, the Plan's review process is not contrary to ERISA.

Next, Franke argues that the Plan is an adhesion contract that should not be enforced. As the Plan points out, however, Franke was not required as a condition of employment to enroll in the Plan. Franke does not assert that negative consequences would follow from any refusal to enroll in the Plan. Thus, the Plan is not a contract of adhesion.

Finally, Franke contends that because the Plan calls for binding arbitration and for the employee to share the expenses of arbitration, it is contrary to ERISA and invalid. There is no dispute that ERISA does not permit binding arbitration, nor does ERISA allow a

benefit plan to charge the costs of arbitration to a plan participant. The Plan argues that the Court should interpret the Plan as if these admittedly illegal terms did not exist, because the Plan provides that, "[s]hould any of the terms contained herein be declared illegal, unenforceable or unconscionable, the remaining terms shall remain in full force and effect." (Berman Aff. Ex. B at 45.) Franke counters that the existence of these provisions renders the Plan's arbitration provisions unenforceable ab initio.

ERISA's regulations are unequivocal: a Plan may not require a participant to bear the costs of arbitrating his or her claim. Indeed, the regulations specifically list such a requirement as an example of a condition that "unduly inhibits or hampers the initiation or processing of a claim for benefits." 29 C.F.R. § 2650.503-1(b)(3) ("For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits.") This regulation makes sense: the presence of a provision requiring a participant to pay to appeal an adverse determination is likely to dissuade some participants from taking an appeal.

The Plan's savings clause is unavailing in this circumstance because the participant cannot be expected to know that the cost-sharing provision is illegal and should therefore be ignored. The mere existence of the illegal provision, in this instance, unduly inhibits or hampers the processing of appeals and therefore renders the arbitration requirement in the Plan unenforceable.

Because the claims review procedures in the Plan do not comply with ERISA, Franke was not obligated to exhaust his administrative remedies prior to filing this lawsuit. See Wert, 447 F.3d at 1063. The Plan's Motion to Compel Arbitration must therefore be denied.

CONCLUSION

Accordingly, IT IS HEREBY ORDERED that Defendant's Motion to Compel Arbitration and to Stay (Docket No. 7) is DENIED.

Dated: March 6, 2008

Filed: 3/12/09
No. 08-1637
UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

James G. Franke, and all others similarly situated,
Appellee,
v.
Poly-America Medical and Dental Benefits Plan,
Appellant.

Appeal from the United States District Court for the
District of Minnesota

ORDER

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

The Plan provides claim payment services. Any claim not presented for payment by March 31st of the year after which the services were rendered will not be eligible for payment. All claims must be presented to the Medical Benefits Department through HIPAA mandated EDI.

1. Contract providers will file all claims directly for you and your coverage Eligible Family Members.

2. Except in very limited circumstances, services and supplies provided by non-Contract providers are not covered by the Plan. However, if you have primary coverage through another plan, you may submit an image of the provider's bill with an explanation of benefits from the primary carrier to be considered for payment. If you have utilized the Plan's Contracted providers, the Plan will consider paying for the remainder of the Reasonable and Customary Charges for Medically Necessary services and supplies up to the Plan's contracted rate. If you are not able to utilize the Plan's Contracted providers under the terms of your primary plan, then the Plan will consider paying (subject to the provisions and exclusions of the Plan) for only the portion of the allowable Reasonable and Customary Charges for Medically Necessary services and supplies not covered by the primary plan.

Requesting a Second Review

If your claim is denied in whole or in part by the Plan Administrator, you may seek a review of this decision.

The following procedures will apply and must be followed:

1. You must file a written request to the Plan Administrator for a review within 180 days of the date the initial claim is denied or in part that states the pertinent facts and provides proper documentation that supports your claim.

2. The Plan Administrator should notify you of the determination in writing within 30 days after receipt of your request for review, unless special circumstances require and extension of time for processing the request. If an extension of the time is required, written notice of this extension will be sent to you prior to the termination of the 30-day period. The written notice will provide you with the date by which the Plan Administrator expects to render a final decision. In no event will this date be more than 30 days after the end of the initial 30-day period.

A written denial of your appeal will contain the following information:

1. The reason(s) for the denial;
2. Specific references to the pertinent Plan provision(s) on which the denial is based; and

3. A description of any additional material or information necessary for you to perfect the claim, and an explanation of why such material is necessary.

Requesting Another Level of Review

If you are dissatisfied with the decision of the Plan Administrator during the review process and your dissatisfaction concerns:

1. the application of the terms of the Plan to this claim;

2. the amount or duration of the payment under the Plan;

3. the performance by the Plan Administrator of the obligation under the Plan; or

4. any interpretation of the Plan by the Plan Administrator,

You may file a request with the Plan Administrator for final and binding arbitration by an impartial arbitrator, as described in the Plan, of the decision about which the complaint is being made. Your request must specify the nature of your disagreement with the decision. You must submit any evidence or information which should be considered and explained the result you desire. The cost of arbitration shall be shared equally by you and the Plan.

FINAL AND BINDING ARBITRATION IS YOUR SOLE REMEDY IF YOU ARE DISSATISFIED WITH YOUR TREATMENT UNDER THE PLAN.

BINDING ARBITRATION.

As a condition to the enrollment of the Employee and his or her Eligible Family Members in the Plan, the

Employee (on behalf of himself or herself and his or her Eligible Family Members) agrees to be bound by the following:

1. Binding Arbitration. Any and all claims, complaints, disputes, demands and causes of action (collectively referred to as "Claims".) that the Employee and/or his or her Eligible Family Members presently have, or may have in the future, against the Company (including any current or former Employee of the Company) and/or the Plan arising from, associated with or connected to the Plan or the provision of, or failure to provide, benefits under the Plan shall be submitted to binding arbitration, irrespective of whether such Claim arises under the federal or state law. The election by the Employee and the Employee's Eligible Family Members to participate in this Plan constitutes a complete waiver of a judge or jury trial in state or federal court by the Employee and the Employee's Eligible Family Members.

2. Term. The agreement by the Employee and the Employee on behalf of his or her Eligible Family Members to arbitrate any and all claims irrevocable, except by written agreement signed by the Employee and the Plan Administrator. The agreement by the Employee and the Employee's Eligible Family Member(s) to arbitrate any and all Claims shall remain in effect throughout the duration of the Employee's employment with the Company and thereafter with respect to any Claim the Employee and/or his or her Eligible Family Members may have

arising from, associated with or connected to the Plan or the provision of, or failure to provide, benefits under the Plan.

3. Grievance Procedures. As a prerequisite to filing a Request for Arbitration against the Company and/or the Plan, the Employee and/or the Employee's Eligible Family Members must first fully comply with the administrative remedies reflected in the Plan's claims procedure. This applies to any claim dealing with or related to in any way with the Plan and/or its administration. Should the Employee and and/or the Employee's Eligible Family Members violate this provision by filing a Request for Arbitration, the Employee and/or the Employee's Eligible Family Members must still comply with the administrative remedies reflected in the claims procedure.

4. Severability. Should any of the terms contained herein be declared illegal, unenforceable or unconscionable, the remaining term shall remain in full force and effect. To the extent possible, both parties desire that the arbitrator modify the Terms declared to be a legal, unenforceable or unconscionable in such a way as to retain the intended meaning of the term(s) as closely as possible.

5. Request for Arbitration. The Employee, the Employee's Eligible Family Members and the Company or Plan shall commence arbitration by a Request for Arbitration. The Employee and/or the Employee's Eligible Family Members shall

submit a Request for Arbitration in writing to the Medical Benefits Department following exhaustion of the administrative remedies reflected in the Plan's claims procedure. The Company or Plan shall submit a Request for Arbitration by delivering the Request for Arbitration to the Participant. A Request for Arbitration, whether made by the Plan, the Employee or the Employee's Eligible Family Members shall include: (a) a detailed description of the Claims asserted; (b) the factual allegations upon which the Claims are based; and (c) the relief requested. Each Claim reflected in the Request for Arbitration must be asserted within one year after the occurrence of the event upon which the Claim is based, or within the limitations period for the Claim in question, whichever is earlier. Failure to timely assert Claims will result in their being barred. The party delivering the Request for Arbitration shall hereinafter be referred to as "Claimant" and the party receiving the Request for Arbitration as "Respondent." Both Claimant and Respondent shall be collectively referred to as the "Parties."

6. Mediation. Within 120 days after the Claimant delivers its Request for Arbitration to Respondent, the Parties shall participate in non—binding mediation. The Parties shall mutually agree upon a Mediator, who shall (i) have been trained in mediation; (ii) have previously mediated or otherwise presided over disputes arising from or related to "employee benefit plans" as such terms as defined in section

3(3) of ERISA; and (iii) be otherwise qualified to mediate disputes. The fees charged by the mediator shall be divided equally between the Parties.

7. Selection of an Arbitrator. All Claims shall be decided by a single Arbitrator, who must: (i) have been trained in arbitration; (ii) have previously arbitrated disputes arising from or associated with "employee benefit plans" as such term is defined in section 3(3) of ERISA; (iii) be otherwise qualified to arbitrate disputes; (iv) agree to be bound by the terms described herein; and (v) agree not to be guided by any authority other than the terms described herein and any governing legal authority. Within 30 days after Claimant delivers its Request for Arbitration to Respondent, the Parties shall begin the process of selecting and Arbitrator. The process for selecting the Arbitrator shall be as follows: Claimant shall propose to Respondent and Arbitrator who meets the above qualifications, at which point Respondent shall either accept the proposed arbitrator or propose a different qualified Arbitrator. Claimant may either accept Respondent's proposed qualified Arbitrator or suggest another. This process shall continue, back and forth, until and Arbitrator is agreed upon. If the Parties have each proposed, and have rejected, 5 qualified Arbitrators (for a total of 10), either Party may petition an appropriate state or federal court to appoint a qualified Arbitrator should the other Party be uncooperative in selecting and Arbitrator. Within 5 days after the selection of the

Arbitrator, Claimant shall provide the Arbitrator a copy of the Request for Arbitration.

8. Expenses. All fees charged by the Mediator shall be divided equally between the Parties. All fees associated with the Arbitration (including, but not limited to, the Arbitrator's fee, court reporter fees and fees to secure a place for the hearing, if any) shall be divided equally between the Parties. However, the total fees incurred by Employee or his or her Eligible Family Members shall not exceed the gross compensation earned by Employee in Employee's highest earning month in the 12 months prior to the time the Arbitrator issues his award.

9. Arbitrator's Authority. The Arbitrator shall be authorized to adjudicate claims, defenses and counterclaims in accordance with this agreement and governing legal authorities. The Arbitrator shall only have the power to adjudicate claims and counterclaims asserted in the Request for Arbitration and the answer thereto. The Arbitrator shall not have the power to grant relief not requested in the Request for Arbitration or the answer thereto. The Arbitrator shall not have the authority to award punitive, exemplary or liquidated damages. The Arbitrator shall not have authority to require the Company to alter or otherwise amend the terms of the Plan or require any action by the Company or the Plan Administrator that is contrary to the terms of the Plan.

10. No Ex-Parte Filings. Copies of all documents

filed by either Party with the Arbitrator must be contemporaneously sent to the other Party.

11. Computation of Time. In computing the deadline for any act described herein, the last day shall not be included if it is a Saturday, Sunday or legal holiday.

12. Representation. The Parties may, but are not required to, be represented by legal counsel at their own expense.

13. Response to Request for Arbitration. Within 30 days following the filing of the Request for Arbitration with the Arbitrator, Respondent shall file its Response to Request for Arbitration. Failure to timely file a Response shall not be considered a default, but shall be deemed a waiver of any counterclaim arising from the facts giving rise to the claims contained in the Request for Arbitration. The Response must contain any affirmative defenses and counterclaims arising from the facts giving rise to the Claims contained in the Request for Arbitration. In the event a counterclaim is asserted, Claimant must file a Response thereto within 30 days of the filing of Respondent's Request for Arbitration, except that failure to timely do so shall not be considered a default.

14. Pre-Hearing Procedure. Pre-hearing procedure shall be as follows:

a. Scope of Discovery. All discovery, both written and oral, must: (i) comply with all provisions

contained herein; and (ii) be reasonably calculated to lead to the discovery of admissible evidence. Financial information about either Party is not relevant and shall not be discoverable.

b. Written Discovery Permitted. At any time after, or contemporaneous with, Claimant's filing of its Request for Arbitration, either Party may serve on the other a maximum of one set of 25 interrogatories (including subparts) and a maximum of one set of 25 request for production/inspection of documents/tangible things. No request for admission may be served. Objections and responses to written discovery must be served within 30 days of receipt of same. A Party whose physical or mental condition is in controversy shall, within 15 days of receiving a written request, provide the other Party with a signed medical authorization.

c. Expert Witness Disclosure. Claimant shall, within 60 days after Respondent files its Response to Request for Arbitration, serve on Respondent: a list of all experts witnesses (including their addresses and telephone numbers) Claimant intends to call at the hearing; each expert's resume or curriculum vitae; and a report prepared by each expert outlining the expert's opinions and the facts upon which they are based. Respondent must then, within 30 days after receipt of Claimant's expert disclosure, serve its own expert disclosure on Claimant.

d. Depositions. Each Party is entitled to take a maximum of one oral deposition (no written

depositions are permitted). Each deposition may last no longer than 6 hours. A notice of deposition must include a duces tecum with up to 10 request for production of documents (these are in addition to the request for production referenced in Paragraph 14(b) above). The Parties must work to schedule the depositions at a mutually agreeable place in time.

e. Independent Examination. Where a Party has placed his physical, mental or economic condition into controversy, the Arbitrator may, upon good cause shown, order the Party to submit to appropriate independent medical and/or vocational examinations.

f. Documents. An evidentiary foundation for relevant documents, including medical records, may be established either through the testimony of a custodian thereof or through a business records affidavit.

g. Subpoenas. Each Party may issue subpoenas directing witnesses possessing relevant knowledge to appear, bring documents and testify (either for trial or deposition). The subpoena need not be in any particular form. However, the witness shall not be compelled to appear more than 100 miles from the place where he/she is located when served with a subpoena.

h. Motions. The Parties may file all motions, including dispositive motions, permitted by the appropriate applicable jurisdiction (as determined by the Arbitrator). Motions must be

responded to within 10 days of being filed, except dispositive motions, for which the deadline to respond will be 20 days from filing. Reply briefs may be filed within 5 days after any responses filed. The Arbitrator shall promptly rule on all motions.

15. Hearing. The Arbitrator shall set the hearing date after consulting with the Parties about mutually convenient dates. The Parties shall be given at least 90 days advance notice of the hearing date. The hearing shall be held at a mutually agreeable location in the County of the Company facilities where the Employee was or is employed. The Claimant shall go first and bear the burden of persuasion on its claims. Any Party asserting an affirmative defense or counter claim will bear the burden of persuasion on such defenses or counterclaim. Each Party will be afforded a full and fair opportunity to present any relevant proof, to call or cross-examine witnesses and to present its argument. A licensed stenographer shall transcribe the hearing. All aspects of the arbitration, including the hearing, records and outcome, shall be confidential. The hearing shall not be open to the public.

16. Award. The Arbitrator's decision and award shall be rendered within 90 days of the conclusion of the hearing, and shall be based solely on the evidence and authorities presented and applicable law, all as interpreted by the Arbitrator. The Arbitrator's decision and award shall be in writing, be issued pursuant to the

terms described herein, signed by the Arbitrator and contain express findings of fact, conclusions of law, discussion of legal authorities and overall rationale. Duplicate original copies of the decision an award shall be sent to both Parties.

17. Appeal. Within 30 days after the Arbitrator issues the Award, either Party may appeal to the appropriate state or federal court, providing that an award shall not be vacated or modified unless all or part of the award resulted from: (i) corruption, fraud, evident partiality or undue means; (ii) the Arbitrator exceeding the powers described herein; (iii) the Arbitrator refusing to hear evidence pertinent and material to the controversy; (iv) the Arbitrator committing an evident material miscalculation figures; or (v) an error of law committed by the Arbitrator (whether an error of law was committed is to review by the court de novo).

18. Record of Proceeding. The Arbitrator shall maintain the record of the proceedings for at least one year after issuing the decision an award. The record of proceeding shall include all pleadings, a copy of this booklet, disposition transcripts, exhibits introduced at the hearing and a copy of the decision and award.

19. Notice. Any notice required herein shall be in writing and sent via certified mail, return receipt requested; and hand delivery with signed receipt; or overnight mail, Federal Express, etc., such that a document evidencing receipt is available, to the Employee or, if applicable, the

Employee's Eligible Family Member(s) at his or her last known home address, and to the Plan Administrator.

20. Governing Law. The Parties agree and acknowledge that, to the extent not inconsistent with this Agreement, this Agreement shall be governed by the Federal Arbitration Act (or, should a court or the arbitrator determined that the Federal Arbitration Act does not apply, by the Uniform Arbitration Act). The Parties further agreed that this Agreement shall be governed by the common law of Texas.

29 § 1022. Summary plan description

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024 (b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024 (b)(1) of this title.

29 CFR 2520.102-3(t)(1)

The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of

typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by Federal law and regulation.

29 CFR 2560.503-1(b)3

The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

29 CFR 2560.503-1(c)2

The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be

provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued

benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.